Procedure: Intrapartum risk factor identification and response

Applies to:

Women allocated to the MCP teams.

Responsibility:

The midwife caring for the woman is responsible for:

- Continual assessment for, and identification of risk factors
- Informing the senior midwife in Birth suite, and
- Initiating the response to the risk factor according to the codes in the table.

Procedure:

1. Ongoing assessment of all risk factors listed in the table below will be undertaken.
2. Assessment of risk factors will be undertaken on admission to birth suite and throughout labour.
3. In the event any risk factor(s) is identified the midwife will respond according to the following code:
   - A = Discuss the risk factor(s) with a senior midwife
   - B = Consult with a medical officer regarding plans for ongoing care
   - C= Consult with medical officer including review of patient, regarding plans for ongoing care
   - D = Transfer responsibility for ongoing care to the medical officer[1, 2, 5].
4. Any risk factor identified, response and plan of action will be documented in the patient record.

Risk factors since last antenatal visit	Code
APH	D
Breech – previously undiagnosed	D
Doppler artery velocimetry - abnormal	D
GBS positive	B/C
Grand multipara	C
Hb <100g/dL when last tested	B
Intrauterine growth restriction - suspected	C
Non-vertex presentation ≥37weeks gestation	D
Oligohydramnios – confirmed by u/sound	D
Pre-eclampsia	D
Prolonged pregnancy ≥42 weeks gestation	D
Prolonged rupture of membranes (>24 hrs)	D
Spontaneous ROM, not in labour	C
>2 admissions for spurious labour	B
VBAC	D
Not in active labour 6 hrs following admission	B
Immediate postnatal - maternal	
Eclampsia	D
First/second degree tear/episiotomy suturing	B/C
Infection - suspected	D
Persistent hypertension	D
Temperature >38 on more than one occasion	D
Thrombophlebitis or thromboembolism	D
Vulval haematoma	D
Immediate postnatal - neonatal	
Abnormal findings on physical assessment	D
Abnormal heart rates or pattern	D
Apgar <7 at 5 minutes	D
Birth injury / trauma	D
Birthweight <2500g	D
Cephalhaematoma	B
Cord (umbilical) <3 vessels	D
Excessive bruising, abrasions, unusual pigmentation and/or lesions	C
Gestation <37 weeks	D
Persistent abnormal respiratory rate and/or pattern	D

Intrapartum risk factors	Code
Epidural analgesia requested	B/C
Epidural analgesia in situ	D
FHR abnormal on auscultation	B
FHR abnormal on CTG	D
Genital herpes active at time of labour	D
Hypertension / Pre eclampsia	D
Induction of labour-prostaglandin/syntocinon	D
Intrapartum haemorrhage	D
Liquor meconium/blood-stained/nil at ARM	C/D
Maternal pyrexia >38^{0}C	D
Oxytocin augmentation	D
Post partum haemorrhage >500mls <1000mls	C
Post partum haemorrhage >1000mls	D
Preterm labour <36 weeks	D
Prolapsed cord or cord presentation	D
Preterm prelabour rupture of membranes before 36 completed weeks	D
Retained placenta	D
Shoulder dystocia	D
Shock	D
Third or fourth degree perineal tear	D
Uterine inversion	D
Uterine rupture	D
Vasa praevia	D
Delay in the progress of labour	
First stage of active labour >12 hours (ie regular uterine activity, cervix >/= 3cm dil.)	B/C
In the presence of regular, effective, expulsive uterine contractions active second stage: a) >1/2 hour in a multiparous b) >1 hours in a nulliparous woman	B & **Start CTG**
In the presence of regular, effective, expulsive uterine contractions active second stage: a) >1 hour in a multiparous b) >2 hours in a nulliparous woman	D
Incoordinate uterine activity after period of active labour	A/B

Reference documents:

RANZCOG Clinical Guidelines for Intrapartum Fetal Surveillance - indicators for continuous EFM (2002)
RCOG/NICE Intrapartum Fetal Surveillance Guidelines (2001)
ACMI, National Midwifery Guidelines for Consultation and Referral (2004)